MEDICAL HISTORY

PATIENT INFORMATION **DATE** ____________________

FIRST NAME	MIDDLE INITIAL	LAST NAME

DATE OF BIRTH	AGE	SEX O FEMALE O MALE	RELATION TO ACCOUNT HOLDER

HOW WERE YOU REFERRED TO OUR OFFICE? ____________________

ACCOUNT RESPONSIBILITY **EMAIL ADDRESS:** ____________________

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT?
O SELF O SPOUSE O MOTHER OFATHER (PARENT IF PATIENT IS A MINOR)

FIRST NAME	MIDDLE INITIAL	LAST NAME

DATE OF BIRTH	AGE	SEX O FEMALE O MALE	SOCIAL SECURITY #

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	CELL PHONE

EMPLOYERS NAME	OCCUPATION	DRIVERS LICENSE #

NAME OF INSURANCE	INSURANCE PHONE #

EMERGENCY CONTACT	RELATION TO PATIENT	PHONE NUMBER

ARE YOU TAKING ANY MEDICATIONS? O YES O NO IF YES PLEASE LIST NAMES OF MEDICATIONS: ____________________

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NAME AND PHONE NUMBER OF YOUR PHYSICIAN: ____________________

IF FEMALE, ARE YOU PREGNANT? O YES O NO IF YES, HOW LONG? ____________________

PLEASE CHECK ONLY IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING MEDICATIONS:

O PENNICILLIN/OTHER ANTIBIOTIC O CODEINE/OTHER NARCOTICS O ASPIRIN O SULFA DRUGS O IODINE
O BARBITURATES/SEDATIVES O LOCAL ANESTHETICS O OTHER ____________________

PLEASE CHECK ONLY THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT THE PRESENT TIME:

O HEART DISEASE O HEART PACEMAKER O ULCERS O THYROID DISEASE O SICKLE CELL DISEASE
O HIGH BLOOD PRESSURE O DIABETES O ANEMIA O CHEMO THERAPY O SCARLET FEVER
O PAIN IN JAW JOINTS O BLOOD DISEASE O ASTHMA O TUBERCULOSIS O ARTHRITIS
O HEPATITIS A B C O EMPHYSEMA O HIV + O VENERAL DISEASE O RHEUMATIC FEVER
O HEART MURMUR O KIDNEY TROUBLE O EPILEPSY/SEIZURES O RHEUMATISM

OTHER: ____________________

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN MY HEALTH, OR IF ANY MEDICATIONS CHANGE, I WILL INFORM THE DENTIST AT MY NEXT APPOINTMENT.

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SIGNATURE OF PATIENT/PARENT/GUARDIAN

MEDICAL HISTORY UPDATE: (FOR THE DENTIST ONLY)

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SIGNATURE OF DOCTOR